



System of Care

Missouri

System of Care: Local Manual

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Manual Introduction

Welcome!

This System of Care manual is meant to help local Missouri providers create and maintain a System of Care within their own communities, usually on the county level. Oftentimes, providers may have a desire to implement System of Care but not know where to start, and they get overwhelmed by the thought of implementation. To help streamline implementation, this manual has compiled many relevant and nationally recognized System of Care resources.

Throughout the manual, tips are provided on how to effectively implement System of Care. Every System of Care will look different as it adapts to the needs of its community. However, keeping the core values and guiding principles at the heart of your work will ensure the System of Care achieves its intended purpose.

Missouri System of Care teams have a long history of wrapping services around youth and their families in counties across the state. Many teams began over a decade ago. System of Care teams continue to exist because System of Care team members know that it works, they see agencies come together, and they see youth and families get better.

The System of Care of tomorrow is supported by Missouri's commitment to System of Care today. By developing awareness and support for System of Care and intentionally bringing families and youth to the table, together we can continue to cultivate and expand positive outcomes for youth and their families.

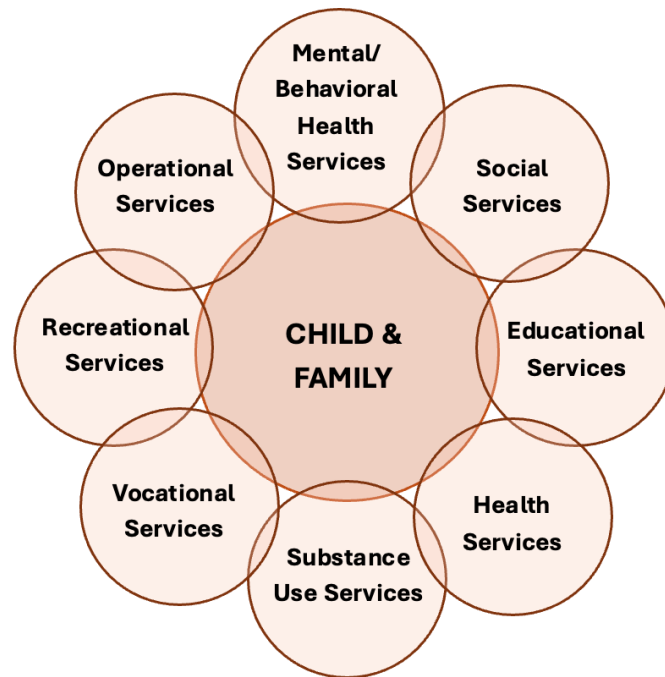
Implementing System of Care in Missouri would not be possible without local champions. If your community finds success with System of Care, we encourage you to spread the knowledge to other communities of the ways in which System of Care helps youth and families positively shift their trajectories.



I. Introduction to System of Care

The System Of Care Approach

“A System of Care is a spectrum of effective, community-based services for children and youth currently navigating or at risk for developing mental health or other challenges, as well as their family support network. A System of Care is organized into a coordinated network, building meaningful partnerships with families and youth, and addressing specific cultural and linguistic needs, to help them to function better at home, in school, in the community, and throughout life.” (Stroul et al., 2010)



From: Stroul & Friedman, 1986

System of Care Core Values

1. Systems of care are family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Systems of care are community-based, with the focus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Systems of care are culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports, and to eliminate disparities in care.

System of Care Guiding Principles

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of service and improve outcomes for children and their families.
4. Deliver service and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of System of Care goals; fidelity to the System of Care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

History of System of Care

The System of Care approach was first developed in the mid-1980's to address significant problems in providing effective treatment for children and youth with serious mental illness and their family supports, including unmet needs for care, overuse of restrictive settings, limited community-based services, lack of cross-agency coordination, and lack of partnerships with youth and their support systems.

Why System of Care?

Many team members currently on a System of Care team often have their own personal reasons why they choose to continue their engagement with System of Care for years to come. In Missouri, this is a small sample of why our providers choose to use System of Care in their work:

We are able to bring everyone together interested in helping families. All of the information other entities have makes us a strong network.

You don't feel alone, there are others out there to give support and share ideas.

It is a collaborative approach, proactive, and prevents triangulation.

I need connection to help me help others.

Hearing from each member helps me understand what agencies can and can't do.

Return on Investment for System of Care (Stroul et al., 2015)

Consistent evidence suggests that Systems of Care provide obvious return on investment, defined as the ratio of the benefits (including avoided expenses) to costs. Return on investment evidence includes:

- Redeploying resources from higher cost and restrictive services to lower cost home-based and community-based services/supports, as well as increased use of these services/supports by youth and families.
- Decreased admissions and lengths of stay in out-of-home treatment settings.
- Cost data suggest per-capita savings across systems.

RETURN ON INVESTMENT EXAMPLES

State	Cost Savings
Georgia	- Inpatient hospital use declined 86-89%. - Psychiatric Residential Treatment Facility use declined 62-73%. - Costs declined by 56%, with estimated per youth savings of \$44,008 annually. - Juvenile correction facility costs declined by 45%, with savings of \$3,180 per youth.
Maine: THRIVE	- Inpatient use decreased by half, 51% savings in Medicaid inpatient hospital costs. - Average per child per month costs decreased by 30%. - Costs for ER visits decreased by 40%.

<i>Massachusetts, MHSPY</i>	- Total per child per month Medicaid claims expenses were less than half for System of Care groups vs comparison group (for physical and behavioral health). - Medicaid claims were 31% lower for ER and 73% lower for inpatient.
<i>Oklahoma</i>	- 41% reduction in average total behavioral health charges vs. 17% reduction for control group. - 60% reduction in average inpatient charges vs. 17% control group. - Savings of \$357 per youth per month, projected savings of \$18 million if all youth participated in System of Care.
<i>Wraparound Milwaukee</i>	- \$3,200 average total all-inclusive cost per child per month vs. \$6,083 group home, \$8,821 correctional facility, \$9,460 residential treatment, and \$39,100 inpatient.

Framework for Expanding System of Care

Stroul et al. (2015) created a strategic framework for System of Care expansion to help guide planning and implementation efforts. This framework consists of five *core strategy areas*, each with specific sub-strategies to help with implementing, sustaining, and expanding systems of care.

The following strategic framework is a summary of Stroul's work and can be used as a structure for organizing the goals in expansion plans and to identify any additional strategies needed to achieve goals of a System of Care. Teams should work to identify goals for the expansion plan, determine which core strategy areas are relevant for what goals, identify strategies in each area that could be used for goal achievement, and customize strategies to best fit the context and goals of the team's plan.

CORE STRATEGIES FOR EXPANDING THE SYSTEM OF CARE APPROACH

Implementing Policy, Regulatory, and Partnership Changes

1.
 - Establishing an organizational focus of System of Care management and accountability at state and local levels.
 - Developing and implementing strategic plans.
 - Developing interagency structures, agreements, and partnerships for coordination and financing.
 - Promulgating rules, regulations, guidelines, standards, and practice protocols.
 - Incorporating the System of Care approach as requirements in requests for proposals and contracts.
 - Enacting legislation that supports the System of Care approach.
 - Incorporating the System of Care approach in protocols to monitor compliance with System of Care requirements.
 - Incorporating the System of Care approach into data systems for outcome measurement and quality improvement.
 - Linking with and building on other system change initiatives (e.g., health reform, parity legislation, reforms in other systems).
 - Expanding family and youth involvement at the policy level.
 - Improving cultural and linguistic competence at the policy level and incorporating strategies to eliminate disparities.

Developing or Expanding Services and Supports Based on the System of Care Philosophy and Approach

2

- Creating or expanding the array of home and community-based services and supports.
- Creating or expanding an individualized, wraparound approach to service delivery.
- Creating care management entities.
- Creating or expanding care coordination and care management.
- Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level.
- Creating, expanding, or changing the provider network with new providers and by retooling and aligning community and residential providers.
- Creating or expanding the use of evidence-informed and promising practices, and practice-based evidence approaches.
- Improving the cultural and linguistic competence of services.
- Reducing racial, ethnic, and geographic disparities in service delivery.
- Implementing or expanding the use of technology (e.g., electronic medical records, telehealth, videoconferencing, e-therapy).

Creating or Improving Financing Strategies

3

- Increasing the use of Medicaid.
- Increasing the use of Mental Health Block Grants, federal System of Care grants, and other federal grants.
- Redeploying funds from higher-cost to lower-cost services.
- Implementing case rates or other risk-based financing approaches.
- Increasing the use of state mental health and substance use funds.
- Increasing the use of funds from other child-serving systems.
- Increasing the use of local funds.
- Increasing the use of federal entitlements other than Medicaid.
- Accessing new financing structures and funding streams (e.g., health reform, parity legislation).

Providing Training, Technical Assistance, and Workforce Development

4

- Providing training, technical assistance, and coaching on the System of Care approach.
- Creating ongoing training and technical assistance capacity.
- Providing training, technical assistance, and coaching on evidence-informed and promising practices, and practice-based evidence approaches.
- Implementing strategies to prepare future workforce to work within System of Care framework.
- Implementing strategies to diversify the workforce by including staff with cultural and language diversity, paraprofessionals, families, and youth.

Generating Support

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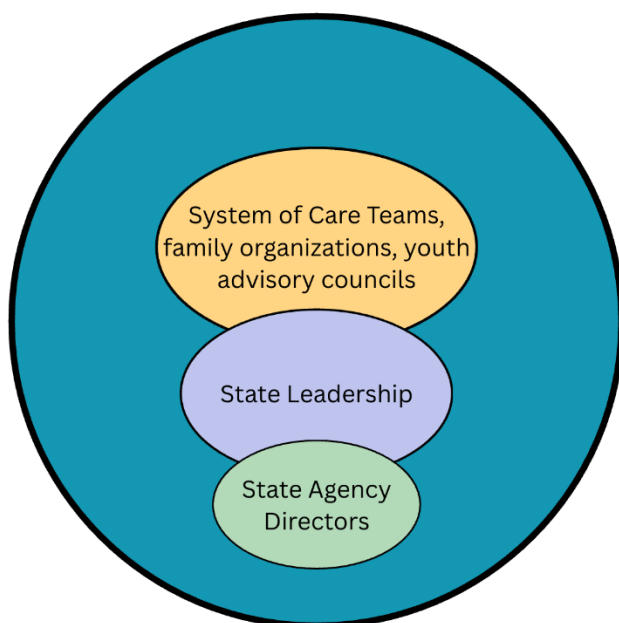
- Establishing strong family and youth organizations to support expansion of the System of Care approach.
- Generating support among high-level policy makers and administrators at state and local levels.
- Using data on outcomes and cost savings to promote expansion of the System of Care approach.
- Cultivating partnerships with providers, provider organizations, managed care organizations, and other key leaders.
- Generating broad-based support through social marketing and strategic communications.
- Cultivating leaders and champions for the System of Care approach.

The strategic framework can be used as a structure for organizing the goals in expansion plans and to identify any additional strategies needed to achieve goals of a System of Care. Teams should work to identify goals for the expansion plan, determine which core strategy areas are relevant for what goals, identify strategies in each area that could be used for goal achievement, and customize strategies to best fit the context and goals of the team's plan.

Missouri System of Care Structure

Missouri's System of Care teams are overseen by local and regional level leadership. Local and regional leadership provide guidance on core values, guiding principles, resources, and technical assistance on necessary components of System of Care. The System of Care Chair maintains an effective referral system, facilitates System of Care team meetings, and tracks outcomes. System of Care teams convene regularly with local family and youth organizations and/or advisory councils to promote family and youth engagement and support for participating on local System of Care teams. State level leadership for System of Care works with state agency directors to promote System of Care and remove.

System of Care Structure in Missouri





Local Level Guidance

II. Start-up and Administrative Tasks

System of Care and Community Characteristics

It is important to note that each System of Care team may look a little bit different. While guiding principles and core values are the same, each System of Care team is supportive of their community values and works to meet the individualized needs of youth, families, and agencies within that community. Knowing and addressing the unique challenges and strengths within each community is an important shared value among System of Care and other community stakeholders across Missouri.

Expansion Summary

How to Create a Team

The first step in creating a team is identifying stakeholders whose input and feedback would be critical to the mission of the team. Potential stakeholders include:

Stakeholder	Examples
<i>Community Agencies</i>	◆ Mental and behavioral health providers ◆ Developmental disability providers ◆ Youth Behavioral Health Liaisons/Community Behavioral Health Liaisons ◆ School districts, including special education services ◆ Child welfare ◆ Juvenile justice and court personnel ◆ Healthcare providers ◆ Housing/shelter ◆ Crisis agencies ◆ Substance use treatment centers ◆ Victim advocacy ◆ Human trafficking coalitions or child safety representatives ◆ Law enforcement ◆ School Resource Officer ◆ Legal aid ◆ Hospital representatives ◆ Residential services representatives ◆ Prevention and positive youth services ◆ Other child and family serving agencies
<i>Family Representatives</i>	◆ Youth, family members, natural support (“nothing about us, without us”) ◆ Youth advocates ◆ Youth Peer Support, Family Support Providers, and Certified Peer Support
<i>Government Entities</i>	◆ Local health departments ◆ Local Department of Mental Health representatives- Division of Behavioral Health and Division of Developmental Disability ◆ Local Department of Elementary and Secondary Education representatives ◆ Local Department of Social Services representatives ◆ Senate Bill 40 Board representatives ◆ Child tax board representatives

Additionally, establishing a team structure is crucial. Each team should have a designated team leader, who is responsible for overall coordination, communication, and decision-making as it pertains to the System of Care. Teams may also decide to develop work groups focused on specific elements relevant to the System of Care, such as service delivery, data collection, or outreach. It is important to create a shared vision for the team, as well as become clear on the values the team holds.

Tip 1. Beginning a System of Care Team

Having a core team of local and regional leaders and decision makers helps build momentum to establish System of Care teams in the communities. Initially, System of Care members need to be patient and continue to meet regularly. This initial group will begin to identify trends, gaps, and make changes to help make improvements and keep it going. Within this group, it helps to have common goals; for example, members might all be invested in promoting tax board legislation.

Consistent and regular messaging about System of Care, including contact information, is key to establishing System of Care in the community. Within the first several System of Care meetings, sharing individual contact information within the team is key to building relationships and maintaining the right contacts and key partners at the table.

Once you get someone to the table, be sure to build off of their knowledge, connections, and resources to add even more stakeholders to the System of Care.

Running an Initial Team Meeting

When first established, it is important for new teams to hold an *initial meeting*. In this initial meeting, the foundation for future work is created. Essentially, any interested person could attend this meeting, and conversation should center around concerns some might have about moving to a System of Care, as well as concerns about the current system. Participants should share why they are interested in pursuing a System of Care approach.

If desired, an experienced outside facilitator, perhaps a leader from a nearby System of Care, may be brought in for the initial meeting. This person could help provide structure and create a productive, respectful environment in which participants feel heard. Collaboration should begin with choosing the facilitator – asking for input from all projected attendees can ensure everyone feels their opinion counts.

During this initial meeting, a mission statement could be formed. A mission statement is the team's general purpose – what are they hoping to achieve. This should be easily understood by professionals and the public alike – be sure to use plain language rather than jargon. The mission statement should be short, around five sentences.

Some questions to consider when developing a mission statement for a local team are as follows:

- ⇒ Why was the team formed?
- ⇒ What are the common values held by each team member?
- ⇒ Who is on the team?
- ⇒ How will members address competing priorities and avoid duplication of work?
- ⇒ What jurisdiction or community will the team serve?
- ⇒ How does the team want to be perceived?
- ⇒ What other functions will the team perform?
- ⇒ What challenges does the team face?
- ⇒ How will the team meet these challenges?

Here are some examples of mission statements from counties across the state:

System of Care	Mission Statement
<i>St. Charles County</i>	"The St. Charles County System of Care is a group of public and private organizations who share core values about how to help support the needs of youth and families. Members work together to foster collaboration, connection, and learning around children's mental health and substance use services for St. Charles County youth."
<i>Franklin County</i>	"Community partners and families working together to provide an array of services to meet the needs of a child at risk."
<i>Missouri's Leadership for System of Care</i>	"To build a collaborative System of Care promoting cross-system communication to comprehensively identify strengths, needs, and innovative ideas to improve coordination of services, provide equitable access, increase stakeholder engagement, and prevent utilization of high-cost services."

Ongoing Team Sessions

It is recommended that System of Care teams meet regularly and often to touch base about goals and plan for future initiatives, though flexibility may be warranted depending on the needs of the local team. It is helpful to use an agenda for the meetings to ensure that they are efficient and helpful for participants. This agenda should be collaborative – that way, all agencies or stakeholders have an opportunity to discuss relevant business. Alternatively, workgroups could identify action items.

A general System of Care meeting notes template is included in the resource section of the manual. The suggested meeting format is as follows:

- ⇒ Round robin introductions.
- ⇒ Organization updates by relevant organization liaisons. This might be events, program information, or trainings, as well as related materials.
- ⇒ Discussion about new referrals.
- ⇒ Discussion about existing referrals.
- ⇒ Potential new partners for the System of Care.
- ⇒ Any miscellaneous but relevant System of Care discussions.
- ⇒ Setting the agenda items for the next meeting.

Tip 2. Maintaining a referral system and meeting structure

Maintaining a consistent and accessible referral system is important work within the System of Care team. Necessary components:

Referral form- A form that identifies the referral source, demographic information for the person being referred to System of Care, the guardian's name and contact info, and contact information for the agency personnel making the referral. It is helpful to include the agencies that are involved or have been involved in the past. The form identifies the individuals residing in the home and their relationship with the youth, the presenting issue, the youth's ability to communicate and respond to others, previous treatment, helpful services and supports, natural talents, interests, school district, whether an IEP or 504 plan is in place, concerns at school, medication, current diagnoses, history of family mental health and/or behavioral health challenges, and includes a description of physician and/or psychiatric care for the youth being referred. When applicable, includes a description of conflict at home, history of abuse, or if young person has perpetrated abuse, and/or law enforcement involvement. This form acknowledges parent consent to share this information with System of Care agencies. Example forms are found in the appendix.

Release of information- This form describes System of Care, provides guidance for all parties when sharing information, and is signed by the parent/guardian. Ahead of the meeting, parents/youth can request certain agencies not be in attendance, and the System of Care Chair is responsible for communicating the parent's/youth's request with that agency. Each System of Care is responsible for ensuring they are properly addressing any legal or ethical concerns.

Meeting structure- It is important to note that consistent meeting structure is key to running a smooth System of Care meeting. One System of Care Chair noted that asking a trained facilitator to lead the System of Care meetings has been a huge part of their success.

At the beginning of each System of Care meeting, there is a sign-in sheet, including a request for contact information with cell and office numbers, and a statement of confidentiality. Parent/guardian should receive a copy of the sign-in sheet following the meeting. The System of Care Chair is responsible for ensuring these documents are created and properly completed.

Also, at the beginning of the meeting, participants are encouraged to avoid negativity and be supportive of the family/youth's strengths. A meeting might start out with what is going well and what are the concerns brought forward by the referral.

All attendees are welcomed, support person/system sits with the youth/family/guardian, introductions are made, a brief description of the System of Care meeting process is provided, and an overview of the work at hand. Questions are welcomed and feedback is encouraged. Several System of Care Chairs noted that asking the family/youth to speak first helps to encourage their participation and alleviates their concerns about how or when they should participate.

At the end of meeting, the System of Care Chair, along with all of the participants, determine the need for follow up care. Following the System of Care meeting, the System of Care Chair sends correspondence via email to all participants summarizing next steps. This correspondence identified the responsible person(s) for follow up.



Local Level Guidance

III. Engagement

How to Invite Partners

Local Family and Community Stakeholders

Here are some ways that System of Care counties can both support and tap into the wisdom of their family leaders:

- ◆ Provide meaningful training and technical assistance to family members, counties, and providers, such as:
 - Training in family involvement, roles and responsibilities, communication skills, and meeting facilitation.
 - Certification as a Family Support Provider. These are caregivers with lived experience supporting a family member with behavioral, emotional, mental health, or co-occurring challenges. They provide peer support, information, and guidance in navigating related systems.
- ◆ Encourage family leaders to develop family networks.
- ◆ Through your system partners, provide financial and/or emotional support to family members of your System of Care as a way of honoring and valuing their contribution.
- ◆ Provide opportunities for family leaders to present information and trainings, serve as committee chairs, assist in interviewing new hires for related agencies, and help plan events and trainings.

Tip 3: Inviting Partners.

Make personal connections, spread through word of mouth, and provide consistent/regular messaging plus meetings. Do people know where to find you? Personal connections begin with a foundation of mutual respect and trust. Successful groups partner often with people in a meaningful way and form deep relationships. Start with a small core team of partners that can help build the System of Care from the ground up.

Best Practices for a Family-driven System of Care:

- ◆ Leadership teams ensure that family members are prepared, trained, supported, and valued.
- ◆ Mechanisms are in place to assist family participation in events such as consultation, compensation (stipends), transportation, travel reimbursement, and childcare.
- ◆ Families have multiple opportunities to provide leadership, advocacy, and support on behalf of other youth and families across the county.
- ◆ Families and systems have a shared responsibility to ensure informed decision-making.
- ◆ Families have a primary decision-making role in the county regarding their youth's and family's care and overall wellbeing.
- ◆ Families are encouraged and supported to find and/or develop family organizations at the local or state level to support family involvement at the system and service-delivery levels.

How to Motivate Team and Local Partners

Keeping a coordinated network of partners and a multidisciplinary team motivated to devote time to System of Care amid their daily work can be challenging. Here are some tips for keeping the team and stakeholders interested and enthused:

- Attend joint trainings as a team and invite stakeholders to trainings.
- Schedule regular and frequent System of Care meetings, while ensuring these meetings are efficient and actionable.
- Find ways to measure progress towards team goals and share progress at meetings.
- Create a respectful environment and check in with team members and community partners to ensure they feel respected.
- Be open and honest with the team (this is easier with a culture of respect!)
- Understand competencies and limits of competency. Know who is the best fit for what job and utilize each other's strengths.
- Clearly define roles and responsibilities on an ongoing basis.

Engaging Families and Youth

Families are a central part of what makes systems of care effective. Family leaders have unique knowledge of their own children, as well as valuable history of navigating various systems to get the care their child needs.

What constitutes a “family”? Essentially, family is often indicative of a group of people who are bound by relation or obligation – while this can and often does include biological families, this can include other significant people in an individual's life. Importantly, families are fluid. Some family members may have the ability to be more actively involved in care, while others may not. When managing a child with significant needs, this can also lead to added stress for family members.

FAMILY INVOLVEMENT – Family participation in systems, services, and community activities are either by request or required by an agency or provider. Agency/Provider staff is primarily responsible for the scheduling of appointments or events. There may be a small number of selected family members invited to participate in leadership opportunities, and family voice and choice are usually not an integral part of this process. Examples of involvement include:

- ◆ Focus on the number of family attending event or meeting.
- ◆ Provide family with resource material and the tracking number of materials distributed.
- ◆ The organization or provider identifies projects, needs, or goals; families are then given options on how they can contribute.
- ◆ Create goals by system or funding requirements with minimal family input on how to reach the goals.

FAMILY INCLUSION – Inclusion is the active and meaningful integration of family members and support persons into the lives of their loved one's resilience and recovery process that is family-centered, culturally responsive, and a strength-based approach to their quality of life and their family. When "included," families will experience the following:

- ◆ Understand the complexities and benefits of being included as part of the implementation of the care and treatment plans.
- ◆ Understand the role of direct care workers, administrators, and policymakers.
- ◆ Understand our own family relationships and how they impact our ability to work with systems, providers, and the individuals in care.
- ◆ Regulations and policies governing mental health care include the rights of families to be involved. Inclusion encourages families to participate in the care and treatment of the individual.
- ◆ Families are included in setting goals and developing case plans. Decisions are made jointly to ensure their children's safety, permanency, and well-being.

FAMILY ENGAGEMENT – Engagement is an equitable partnership between families and staff. There is shared responsibility across administration, staff, and families that is strength-based, culturally responsive, and embedded in all work. Family and staff work mutually together to accomplish change that is in the best interest of the child, youth, individual, and family. Family engagement is characterized by the following:

- ◆ Goals created with or by families, based upon what families think, dream, or have concerns about.
- ◆ Families and staff reflect the diversity of the community (race, ethnicity, language, education level, and geography.)
- ◆ Partnerships with established and maintained with family-led and community-based organizations.
- ◆ Access to relevant knowledge is provided.
- ◆ Transparency and partnership exist in all parts of the process.
- ◆ There is an evaluation of changes and what the system or organization is doing differently because of engaging families with lived experience.
- ◆ Engagement is a core value and can be understood as, “Nothing about us without us.”
- ◆ Established engagement at all levels, from the individual family level to families in leadership and advisory roles.
- ◆ The goal of family engagement is to gain partners, not to "serve clients."

Tip 4: Engaging family and youth partners

- ⇒ Family organizations are invited from the beginning.
- ⇒ Build on established relationships to create engagement and buy-in.
- ⇒ Key leaders can facilitate connections to important partners. For example, school partnerships are more easily established when there is a key change agent who maintains those relationships from previous experiences at the school.

- ⇒ Facilitator intentionally and pointedly asks for feedback and opinion of youth and family members in attendance.
- ⇒ Conversations about involvement and engagement with youth and families and the order in which they provide feedback during the System of Care meeting are important. This takes the guess work out and reduces anxiety for them about how and when they can participate in conversation. Families speaking first is effective- “give them the floor.”
- ⇒ A System of Care team member, assigned as a support person for the family, can brief the family and youth to prepare them for the meeting. This would include the number of those in attendance, their role, what and how they plan to share.



Local Level Guidance

IV. Tracking Outcomes

Team Assessment

System of Care teams should engage in regular, frequent outcome assessment to ensure their team is working towards their goals and providing appropriate services to children and families. It is important for System of Care teams to be able to tell their story. Data helps teams communicate and describe how the team is making positive change in the community. Multiple assessment tools are available at the end of this manual for use in outcome measurement.

Family Outcome Assessment

Another crucial area of assessment is at the family level.

Some areas of assessment include:

- ◆ Reductions in days-out-of-home placement, including inpatient hospitalization and foster care.
- ◆ Decreases in school suspensions and detentions.
- ◆ Decreases in contact with law enforcement.
- ◆ Decreases in self-harm and suicide attempts.
- ◆ Decreases in problem behaviors.
- ◆ Increases in resiliency.
- ◆ Clinically significant improvement in functioning.

Tip 5: Monitoring team and family/youth outcomes

Monitoring outcomes is essential to sharing successes and improving supports. The System of Care team needs to be intentional about collecting and monitoring outcomes. Even if this is a very basic process, it will improve and strengthen System of Care supports and services.

Improving outcomes might include monitoring transitions. This may include a warm hand off to other services, agency treatment team at the close of the System of Care process, or an open-door policy to accept young people returning.

Collecting feedback from System of Care members and youth and families served is another way to build in outcome monitoring and data collection. System of Care teams welcome feedback about established procedures. Teams can be intentional about when and how this feedback is received and integrated into practice.

Outcomes might include consistent engagement in services, medication management, youth attending school on time, or improved relationships.

In Closing...

System of Care would not be possible without all of the incredible work carried out by all of Missouri's community, local, and state stakeholders who do this work to make a difference in the lives of children, youth, and families.

We thank you for your dedication to the betterment of our services and are excited to see how local systems engage with System of Care in unique and meaningful ways.

Missouri's System of Care Contact:

JJ Gossrau, LCSW

Missouri Department of Mental Health

SystemOfCare@Dmh.Mo.Gov

JJ is available as a source of support as you begin your System of Care journey. Please let her know if you have any questions. JJ can help connect you to regional System of Care leadership in your area!

[Missouri's System of Care Website](#)

References for Evidence Based Practice:

[California Clearinghouse \(CEBC\)](#)

[Evidence-Based Practices Resource Center - SAMHSA](#)

[National Child Traumatic Stress Network \(NCTSN\)](#)

System of Care References:

[Toolkit for Expanding System of Care](#)

[Pennsylvania Care Partnership](#)